TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SENTRIX PHARMACY AND DISCOUNT LLC

Respondent Name
SENTINEL INSURANCE COMPANY LTD

MFDR Tracking Number
M4-17-0496-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sentrix Pharmacy and Discount, LLC (the 'Pharmacy') requests payment for the services rendered to [injured employee] on 08/05/16. The service rendered was the filling and dispensing of prescription medication. The claim(s) in question were properly submitted pursuant to the Pharmaceutical Benefits rules codified in 28 Texas Administrative Code (TAC) §134.500 through §134.550.

The insurance carrier, The Hartford, failed to take final action within the 45-day period set forth in TAC §134.240 [sic]. Specifically the claim was submitted on 8/5/16 and it was received by the provider on 8/10/16 (as verified by the attached proof of delivery) and no action was taken on the claim. Sentrix made a good faith effort to notify the carrier of their failure to respond to the bill on 9/26/16 and it was received by the provider on 9/30/16 (as verified by the attached proof of delivery). Again, no action was taken on the claim. "

Amount in Dispute: $2,568.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Letter dated November 15, 2016: "We have received the RX request from the provider. It is currently in peer review."

Response Submitted by: The Hartford, 300 S. State St., One Park Place, Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2016	Pharmacy services – Compound 240 Grams	$2,568.98	$2,568.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.240 sets out the procedure for medical bill processing by the workers' compensation insurance carrier.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the reimbursement for pharmacy services.
5. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
6. No explanation of benefits were found in the documentation.

Issues

1. Did Sentinel Insurance Company LTD, reduce or deny the disputed services not later than the 45th day after receiving the medical bill?
2. Is the requestor entitled to additional reimbursement?

Findings

This medical fee dispute was filed by health care provider Sentrix Pharmacy and Discount LLC on October 24, 2016. Sentrix Pharmacy and Discount LLC (Sentrix) on its table of disputed services asserts that it was not paid by Hartford, an agent of the carrier, for the compound it dispensed to a covered injured employee on August 5, 2016.

1. Sentrix contends that Hartford "…failed to take final action within the 45-day period set forth in TAC §134.240 [sic]." Furthermore, in its reconsideration request, Sentrix also alleges that "Sentrix has not … received any sort of notification or EOBR."

   According to Texas Labor Code Sec. 408.027 (b) Sentinel Insurance Company LTD was required to pay, reduce or deny the disputed services not later than the 45th day after it received the medical bill from Sentrix. Corresponding 28 Texas Administrative Code §133.240 also required Sentinel Insurance Company LTD to take final action by issuing an explanation of benefits not later than the statutorily-required 45th day.

   The following evidence supports that Sentinel Insurance Company LTD initially received the medical bill for the services in dispute on August 10, 2016.

   - A copy of a certified mail receipt dated August 5, 2016 number 9400 1118 9956 3079 5501 76 addressed to Hartford, an agent of Sentinel Insurance Company LTD.
   - A copy of a corresponding USPS tracking printout indicating that Hartford received certified mail number 9400 1118 9956 3079 5501 76 on Wednesday August 10, 2016.

   Although there is evidence that Hartford received a medical bill for the service in dispute on August 10, 2016. Hartford failed to timely take the following actions on behalf of Sentinel Insurance Company LTD:

   > Rule §133.240 (a) An insurance carrier **shall take final action** [emphasis added] after conducting bill review on a complete medical bill…**not later than the 45th day** [emphasis added] after the insurance carrier received a complete medical bill."
   >
   > Rule §133.240 (e) The insurance carrier **shall send the explanation of benefits** in accordance with the elements required by §133.500 and §133.501 of this title…The explanation of benefits shall be sent to:
   >
   > (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill…

   Furthermore, Sentinel Insurance Company LTD failure to timely issue an explanation of benefits to Sentrix Pharmacy creates a waiver of defenses that The Hartford raised on behalf of Sentinel Insurance Company LTD in its response to medical fee dispute resolution. According to Rule §133.307 (d)(2)(F):

   > 28 Texas Administrative Code §133.307 (d)(2)(F) The [carrier's] response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The Division concludes that Sentinel Insurance Company LTD's failure to timely issue an appropriate explanation of benefits creates a waiver of any new defenses **including those presented in its response to medical fee dispute**. Absent any evidence to the contrary, the Division finds that the services in dispute are eligible for payment.

2. Rule at 28 Texas Administrative Code §134.503 applies to the compound in dispute and states, in pertinent part:

> (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
>
> (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
>
> (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
>
> (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
>
> (A) health care provider; or
>
> (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502 (d)(2).

Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price Gm	Total Gm	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) and (c)(2)
Salt Stable Base	00395602157 Generic	$3.36	145.92	$612.86	$490.29	$490.29
Baclofen	38779038808 Generic	$35.63	9.6	$427.56	$342.05	$342.05
Amantadine	38779041109 Generic	$24.225	19.2	$581.40	$465.12	$465.12
Clonidine	38779056105 Generic	$206.625	0.48	$123.98	$93.48	$93.48
Dimethyl Sulfoxide	38779061409 Generic	$1.24	12	$186.00	$14.88	$14.88
Amitriptyline	58597800308 Generic	$19.15	4.8	$114.90	$91.92	$91.92
Gabapentin	58597801407 Generic	$62.84	12	$942.60	$754.08	$754.08
Ketoprofen	58597801707 Generic	$10.97	24	$329.10	$263.28	$263.28
Lidocaine	58597802007 Generic	$4.49	12	$67.35	$53.88	$53.88
NA	NA	NA	NA	$15.00 fee	$0	$0
		Total	240		Total	$2,568.98

The total reimbursement is therefore $2,568.98. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $2,568.98.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,568.98, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/7/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.